



Department
of Health &
Social Care

From Ashley Dalton MP
Parliamentary Under-Secretary of State
for Public Health and Prevention

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Professor Kevin Bampton
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By email to: kevin.bampton@bohs.org

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Dear Professor Bampton,

Thank you for your correspondence of 22 January, 18 March and 1 May on behalf of the COVID-19 Airborne Transmission Alliance executive team about COVID-19 transmission. I apologise for the delay in replying.

I appreciate your concerns.

The *National infection prevention and control manual for England* (NIPCM) provides adaptable guidance to support local decision-making. It is regularly updated in response to emerging scientific evidence, feedback from frontline healthcare staff, and system needs. As committed to in the 2024-29 UK national action plan to confront antimicrobial resistance, the literature reviews that inform the evidence-based recommendations within the NIPCM are being updated. Updating the NIPCM involves consultation with a team of healthcare professionals from a range of specialties and care settings, including frontline healthcare staff, the UK Health Security Agency (UKHSA), the National Institute for Health and Care Excellence (NICE), the Health and Safety Executive (HSE) and the Care Quality Commission.

The NIPCM methodology outlines the steps and processes involved in maintaining and updating the manual. Updates are disseminated appropriately to healthcare employers and providers to support consistent implementation. All updates, including their rationale, are publicly available to ensure accountability and engagement with stakeholders. Further information can be found at www.england.nhs.uk/long-read/national-infection-prevention-and-control-manual-methodology.

Healthcare organisations are responsible for conducting dynamic risk assessments to determine when enhanced infection control measures, such as the use of FFP3 masks, are necessary. These assessments take into account factors such as ventilation quality, local infection prevalence and specific care environments.

While the findings of the UK COVID-19 Inquiry, especially in relation to Module 3, have yet to be published, the Inquiry's findings regarding infection prevention and control (IPC) will be carefully considered. The Government's position is informed by scientific evidence, which shows that while SARS-CoV-2 can be transmitted through the airborne route, it is not predominantly spread this way. Numerous factors must be considered when assessing transmission in different environments. Guidance on transmission routes can be found at www.gov.uk/government/publications/sars-cov-2-transmission-routes-and-environments-22-october-2020.

Since 2022, the UKHSA has stated that when someone with COVID-19 breathes, speaks, coughs or sneezes, they release droplet and aerosol particles containing the SARS-CoV-2 virus. SARS-CoV-2 is primarily transmitted between people through these infectious respiratory particles (droplet and aerosol) when they are inhaled or come into contact with the eyes, nose or mouth. Aerosol-generating procedures can result in the release of aerosols from the respiratory tract when these are performed in health and care settings. Transmission risk is highest in close proximity to an infectious person, particularly within two metres. The number of infectious respiratory particles is greatest close to the nose and mouth. Being in poorly ventilated indoor spaces, particularly over an extended period of time, also increases the risk of becoming infected.

Indirect transmission can occur through contact with surfaces contaminated with the virus; however, the relative risk is likely to be lower than for other routes of exposure, though this route may still be important in higher-risk settings. The full guidance can be found at www.gov.uk/government/publications/wuhan-novel-coronavirus-background-information/wuhan-novel-coronavirus-epidemiology-virology-and-clinical-features.

This is consistent with the World Health Organization's (WHO's) published advice on the transmission of SARS-CoV-2. Neither the UKHSA nor the WHO refer to a predominant mode of transmission of SARS-CoV-2 in their published information.

The idea that COVID-19 is predominantly transmitted through the airborne route has been stated in scientific literature and public health documents, although the wording and emphasis vary depending on the source and publication date. The Chief Medical Officer acknowledged this during evidence to the Inquiry, noting that *there is still uncertainty now about whether aerosol is the dominant route of transmission of SARS-Cov-2. Whilst over the course of the pandemic, the national and international understanding of the contribution of airborne transmission evolved, the precise delineation of particle sizes and the extent to which evidence supported a dominant transmission route through different stages of the pandemic remains unclear.*

In April 2024, the WHO and partner public health agencies published a global technical consultation report that introduced updated terminology to describe how pathogens are transmitted through the air. They proposed the general descriptor 'through the air' for infectious diseases where the main mode of transmission involves the pathogen travelling or being suspended in the air. Under this umbrella, they defined two specific descriptors:

- 'short-range airborne transmission' refers to the spread of pathogens through the air over short distances, typically within close proximity to an infected individual; and
- 'long-range airborne transmission' describes the spread of pathogens through the air over longer distances, beyond the immediate vicinity of the infected person.

This updated terminology aims to clarify the characterisation of transmission modes of various pathogens. However, the WHO did not explicitly state in this report that SARS-CoV-2 is predominantly spread by the airborne route. Instead, the report focuses on refining the language used to describe airborne transmission in general. It is important to note that while the WHO has acknowledged that SARS-CoV-2 can spread through aerosols, especially in certain settings, it has also emphasised that the virus is primarily spread through close contact with infected individuals and exposure to respiratory droplets. The degree to which airborne transmission contributes to the overall spread of COVID-19 remains a subject of ongoing research and discussion within the scientific community. The report can be found at www.who.int/publications/m/item/global-technical-consultation-report-on-proposed-terminology-for-pathogens-that-transmit-through-the-air.

The NIPCM guidance for England takes a nuanced approach to aerosol and droplet transmission, moving beyond academic distinctions in particle size to focus on practical implications within healthcare environments. This enables the effective application of evidence-based recommendations in clinical practice by all healthcare staff. The NIPCM provides non-pathogen-specific recommendations to address a wide range of IPC challenges. NHS England is evaluating evidence related to transmission-based precautions (TBPs), including respiratory transmission, aerosol behaviour, aerosol-generating procedures and personal protective equipment use, to ensure that guidance continues to be informed by the latest evidence. Recent findings from the WHO and the TBPs literature review undertaken in Scotland highlight the complexity of TBPs. Factors such as the transmissibility of the infectious agent, the type of intervention being performed, the duration of exposure, and the care environment should all be considered when determining appropriate IPC measures. The NIPCM notes that the distinction between droplet and aerosol transmission is not always clearly defined.

Compliance with the *Control of Substances Hazardous to Health (COSHH)* guidance is paramount to the safe delivery of healthcare across England. NHS employers hold the primary legal responsibility for healthcare staff safety, supported by the regulatory role of the HSE. Managers and employees are instrumental in upholding safety standards, while NHS boards provide strategic oversight to ensure safety initiatives are integrated into broader healthcare operations. To ensure full alignment with regulatory standards, NHS England is reviewing the hierarchy of controls within the NIPCM, emphasising the importance of controlling the source of infection and appropriate respiratory protective equipment for staff in all care settings to reduce risk. This includes consultation with the UKHSA, NICE and the HSE.

The *Biological agents: Managing the risks in laboratories and healthcare premises* guidance has been withdrawn and is no longer available on HSE webpages. There are no plans to update and reissue this guidance. The HSE has published guidance for the management and operation of microbiological containment laboratories, which will apply to laboratories in healthcare settings and can be found at www.hse.gov.uk/biosafety/information.htm.

Communications and community engagement are an important part of outbreak management. They enable populations to be informed and support individuals to take action to reduce the risk of transmission and harm in the context of an outbreak. In outbreaks requiring a vaccination response, the UKHSA, NHS England, integrated care boards and local authorities should work in collaboration to ensure effective messaging is delivered to relevant population groups, proportionate to the scale of delivery needed.

I hope this reply is helpful.

Yours sincerely,

A solid black rectangular box used to redact the signature of Ashley Dalton.

ASHLEY DALTON